COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

IN RE: PHARMACY TAC

May 21, 2019
9:30 A.M.
Department for Medicaid Services
Commissioner's Conference Room
275 East Main Street
Frankfort, Kentucky

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Appearing telephonically:

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AGENDA

1. Call to Order, Welcome & Introductions

2. Approval of Minutes/Report from the March 5, 2019 PTAC meeting

3. Additional Discussion Topics/Reports/ Action Items
   * Roundtable report out on current state of affairs
   * Department of Medicaid
     - DMS MCO Coverage of Pharmacy-Based Immunizations Chart edits
     - Update on 1115 Waiver and implications
       * Adjudication message to include FPL for copays for pharmacies and providers
     - Senate Bill 5 data report release update
     - Communication collaboration between DMS and KPhA
     - DMS Pharmacy Department Project Manager
   * CareSource
   * Aetna
     - CPESN pilot project update
   * WellCare
   * Anthem
   * Passport
   * PTAC Committee members

4. Follow-up on previous agenda items
   * Potential pilot programs to improve outcomes
   * Improving quality of care by leveraging pharmacists in Kentucky
   * Update from DMS: focus for improving outcomes

5. New Business/Take-aways
   * CVS Caremark representatives contact
   * 90-day supply for medications

6. Reports and recommendations from the PTAC to the MAC

7. Other Business

8. Next Steps
   * Next MAC meeting - May 23, 2019
   * Next PTAC meeting - July 23, 2019

9. Adjourn

DR. FRANCIS: I will call us to order. We're going to go ahead. We have lots of new members in the room. So, let's take some time for introductions.

We have five members of the TAC. We just went through our cycle of renomination by the Kentucky Pharmacists Association. Each year, we have one or two members that cycle off and are up for renomination.

Paula was just nominated for her three-year cycle this past month. I will let Matt introduce himself but Matt Carrico is taking Rob Warford's place on the TAC. So, he is our new Pharmacy Technical Advisory Committee member and this is his first meeting. So, thank you, Matt, for serving.

(INTRODUCTIONS)

COMMISSIONER STECKEL: If I could, Madam Chairman, let me go and introduce the new staff. I'm thrilled that we're finally getting staffed up and hopefully things will be smoother, but Dr. Theriot is our new Medical Director. She is a pediatrician by training and comes to us from the Office of Children with Special Health Needs. So, a lot of really good experience but we are excited

about having her on board and she will be reaching out to you all and you should feel comfortable doing the same.

Genevieve Brown is our new Chief of Staff and I am thrilled that she is on board also because she will be taking on special projects and various, assorted functions that I've tried to get done but couldn't along with Program Integrity and that will be her primary focus but there will be other things.

She has been here for a whole six days. There will be other duties as assigned but she is a resource also for you all. She is an attorney by training and a lot of good provider experience in the legal field.

These will be two resources for you all if I'm not available or Jessin or Doug are not available.

DR. FRANCIS: Would it be possible to put an email address in the minutes?

COMMISSIONER STECKEL: Sure. We'll be glad to put their contact information out there.

(INTRODUCTIONS)

DR. FRANCIS: Thank you for

doing the minutes last month. I sent out the minutes that were sent to us and I had a few edits on them and I sent them out, but do we have any approval with the changes of the minutes? I know that Angela gets them from KPhA and she sent it out, I believe, to everyone at least that was in attendance last time.

MS. MILLER: I will move to approve them.

DR. BETZ: Second.

DR. FRANCIS: So, by Paula and Chris, the minutes from the March 5th meeting are approved with the changes that I gave.

So, we will dive right in, then, today. Lots going on I think in the state and I'm thrilled that the Pharmacy Department has additional resources but we always give DMS some time to kind of update us, give us what's going on.

I did list some bullets here of topics from last time and additional topics, if you want to hit on those Commissioner. So, we will start with you.

COMMISSIONER STECKEL: Thank you. There is a lot going on, and I'm going to skip through and then defer to Doug on some of the other issues.

The thing that is taking up almost of my time - I laugh. I told my husband last night, I said this is what my life has become. It's either pharmacy reimbursement or urinalysis drug testing, but complying with SB 5 is really consuming most of our time.

I hope that you all feel like we've kept you in the loop. I know we've talked to Shannon a good bit. We're trying to be as open with everybody - the MCOs, the PBM's and the independent pharmacies - about what we're trying to do.

The struggle is, do you all know the story of the Gordian knot? There's a thing called a Gordian knot and the more you tug on it, the tighter it gets instead of unknotting and I feel like this is a Gordian knot; that we're struggling with a bill that was poorly written for good, bad and indifferent reasons, a process that we are having to be very sensitive to.

If by implementing SB 5, do we make it worse for the independent pharmacies or better? And I will explain some of that and, then, have Doug help me explain some of it and, then, just how do we make sure we're implementing it operationally with the PBM's and the MCOs.

So, what we have decided currently - and I've got a meeting with the Secretary tomorrow to try to walk through some other issues - is that we have told the MCOs and the PBM's that they have to go back to April 1st pricing. So, from April 1st to May 31st, the April 1st pricing will prevail.

Now, on Friday we're supposed to get data from the PBM's that shows by pharmacy the impact of doing that.

Now, the reason we've asked for that information is what scares me to death is that we're going to get the data and going back to April 1st, it's going to cost pharmacies more than it isn't.

We saw some dramatic price decreases; but when you look at the totality of the price changes, that's what we want to see. So, by pharmacy, we will know the adjustments back to April 1st, plus or minus.

Did I say that right?

DR. OYLER: Yes, that's correct. At least some of the concerns were potentially instances where reimbursement may have increased by more than "x" percent or more than 5% or whatever. So, trying to get the net impact of all of

that to each individual pharmacy is what we're hoping to see.

COMMISSIONER STECKEL: And I should say that this is applicable to the MAC pricing changes.

Now, the AWP and the WAC pricing, the manufacturer-controlled pricing we're going to deal in a different way. So, the MAC pricing was the one that seemed to be causing the more significant problems.

So, on June 1st, they will go back to April 1st and there should be a reconciliation of dollars back out to the pharmacies at that time or there's a potential that a pharmacy may owe money back to the MCO if their mix of drugs is such that it means the prices have gone up more than they have gone done.

DR. FRANCIS: What is the reimbursement supposed to be? What is the standard that you're setting, I guess? How do they determine if they owe?

COMMISSIONER STECKEL: Why don't you explain it.

DR. OYLER: So, it will go back to what it was on April 1st. So, if reimbursements

to the pharmacy had changed by more than 5% from April 1st. So, everything is being reset back to that time to what reimbursement was then. But it's possible that reimbursement to a pharmacy may have increased compared to April 1st pricing for a given drug or given a mix of drugs that that pharmacy dispenses but the net reimbursement may have actually increased to one specific pharmacy but decreased to the majority of pharmacies.

So, there could be some kind of unintended impact on the number of pharmacies where net reimbursement could have actually increased. Am I making sense?

DR. FRANCIS: Yes. So, we want the total reimbursement, despite what formula of drugs that they're dispensing, to be 5%.

COMMISSIONER STECKEL: So, we're going drug by drug--so, let me step back and give you kind of here's the problems that we're dealing with.

One, there was a guidance that was issued by DMS in June of 2018 that was incorrect. It clearly was not in compliance with the law but it was the guidance given by DMS and the MCOs and PBM's acted upon that guidance, as they should have.

So, we've had to rescind that guidance and issue new guidance. So, what we're having to do is deal with a period of time between April and June that we're trying to fix a problem that we, DMS, created. And, then, after June, it will be the policy of looking at 5% and up or down.

Now, the problem we, DMS, have and what we're struggling with is we've retained Myers & Stauffer to create a process for us to do this electronically so that it's easier and more administratively simplified, but they're not going to have that system up until December 1st.

So, what we're struggling with is how do we deal with the potential of hundreds of changed drugs every day and approving that. So, that's what we're struggling with.

And I know everyone is frustrated. We're just as frustrated but we are trying.

DR. FRANCIS: It sounds like you've made progress.

COMMISSIONER STECKEL: Yes, I think we have. I think we have.

So, the issues that we're fearful about - and this is in just full disclosure -

is that when we get that data on Friday, there are more pharmacies that are going to have to pay back money than think that they're going to get money.

So, we're going to evaluate that data. We will be coordinating with our pharmacy associations and with the MCOs and the PBM's. It very well could be that we all have to have an emergency meeting and figure out what the heck we're going to do.

MR. GRAY: And, Carol, there's no floor or ceiling relative to how that all works out, right?

COMMISSIONER STECKEL: Correct, exactly. Good point.

DR. FRANCIS: And at the last PTAC meeting, we talked about potentially getting together a quorum of pharmacists that you would speak to - it might have been the last one or the one before that. Were you able to do that? Did KPhA help get together some pharmacists and maybe reconvene that, depending on the results of this in June?

COMMISSIONER STECKEL: I know we've reached out to Shannon. Today what I'm trying to do is to send out what we're looking to do to KPhA

and we've talked to a couple of pharmacists to see, does this sound reasonable? Does it not sound reasonable? So, we can certainly do that.

And, then, after we get the data on Friday, if it goes the way we would like it to go, and that's checks are going from the PBM's/MCOs to the independent pharmacists, then, we'll just stay with that policy.

If there are either significant anomalies or it's what we're afraid of, then, we would have to regroup and we would bring in folks, absolutely.

DR. FRANCIS: So, we will be able to tell after June 1st.

MS. STIGLITZ: I just want to make sure I have this clarified in my mind. The problem started, going back to my beginning because my simple brain has to think this way, the problem started April 16.

The guidance was rescinded I think around May 8th and it said effective immediately, there is new guidance that says "x".

It is my understanding that from the period that the cuts started in reimbursement to that date when the new guidance was

issued that pharmacies will not receive retroactive reimbursement for that time period.

COMMISSIONER STECKEL: I thought we were going back to April 1st.

DR. OYLER: Yes. So, that would be retroactive. We would go back to April 1st with the correction for the necessary change in reimbursement, up or down, to the pharmacies from April 1st through May 31st.

COMMISSIONER STECKEL: And we have been clear to the MCO/PBM's that they have to do the re-filing of everything, that they're not to put it on the pharmacies.

MS. STIGLITZ: They will automatically reverse. No additional fees for reversing and rebilling to the pharmacy.

COMMISSIONER STECKEL: No.

MS. STIGLITZ: And, so, from the date the new guidance was issued to June 1st, they will actually get reimbursement back from June 1 to April 1. That's sort of your time frame.

DR. OYLER: That's correct.

MS. STIGLITZ: Okay. I just wanted to clarify that.

COMMISSIONER STECKEL: It's

very helpful because this is very confusing. And I have been doing the same thing every time we get together.

So, here is the other confounding factor, as if we needed another one. GER, we all have been worried about what happens. We have gotten WellCare's data because they're a pass-thru pharmacy. So, that was like the canary in the coal mine, but we know that this is going to hit four times stronger when the GER's are done.

So, one of the things that we are talking - I think we're talking - if not, we will be talking to the MCOs about - is taking this calculation out of any GER calculation so that if you've made an adjustment in that April through June 1st period, that that cannot be calculated in a GER adjustment because, then, what we don't want to have happen is that at the end of the quarter or the year when GER adjustments are done, then, all of a sudden, you may have gotten a check to reconcile and now we're going to take back three times that amount because of the GER.

Anything else you want to add on that?

DR. OYLER: I don't think so.

COMMISSIONER STECKEL: So, we're struggling with that and what do we have the authority to do? How can we make sure that we're addressing the GER's in this because we knew from the beginning that that was going to be a tsunami unlike one we're now experiencing which is the WellCare data.

So, any other confounding point I'm leaving off?

DR. OYLER: Nothing that comes to mind immediately, no.

DR. FRANCIS: So, this does include all of the PBM's and WellCare?

COMMISSIONER STECKEL: Correct. WellCare has a PBM. It's just their contract is different. So, that's why we knew the changes in the rates quicker with them than the others.

I wish it were a whole lot easier for all of us, but we recognize the impact on the pharmacies. We recognize our responsibility on implementing SB 5.

And what we're having to do in a lot of cases is say this is the statute. It is not the easiest. It may not make the most administrative sense but it's what the statute says. So, we're

going through all of these steps trying to comply with SB 5.

Now, the second stage that we would like to ask the TAC and the associations to help us with is, as we get this settled and we know what we're going to do, what the impact is in real dollars, we would like to revise the statute so that we can make it a better, more efficient statute.

And we understand what everyone wants us to do and that's not let the PBM's up or down, but what we've created is an environment where they can literally go up every single day 5% and there's nothing we can do.

So, we need to start thinking about would it be better to look at aggregate? Would it be better to look at a period of time? We don't know the answer to that question but we'd like to work with you all and come forward with a proposal to amend the statute so that we're actually accomplishing what you all are trying to accomplish. Does that make sense?

DR. FRANCIS: Yes.

COMMISSIONER STECKEL: And we have warned - and any of the MCOs in the room, I would suggest you take this to heart - we have warned

the MCOs and the PBM's that we are going to be tracking in the aggregate. So, if we start to see that 5%, 5%, I don't know what we can do but it will be something.

MS. STIGLITZ: Well, you can set the rate, too. I mean, that is very clearly in the statute. And while I agree that the other language is not written in the best manner and can lead to confusion, there is always the--I mean, setting the rate is pretty clear and straightforward within the statute.

COMMISSIONER STECKEL: Absolutely. I just don't like price things but that may be what we have to do. And, of course, I have already had legislators talk to me about carving out pharmacy. I've also made it clear that DMS is tired of fighting that battle, so, we aren't anymore.

Our preference is that services be carved into managed care, but I'm not taking that battle on again. We're running data and we're running numbers on the cost benefit analysis of it being done either way.

MR. KAYE: Obviously you've got a can of worms, to say the least. If pharmacies don't get adequately paid, then, they're going to

remove themselves from the networks which will then put the MCOs in jeopardy based on adequacy of network.

It's going to be up to the MCOs to satisfy their retail pharmacy outlets, but your comments on trying to calculate the prices, that is a heroic experience, to say the least.

COMMISSIONER STECKEL: Thank you.

MR. KAYE: The data comes out from First Databank or some other data-reporting institutes on a daily basis. It usually comes to the retail pharmacy and they automatically upload to the pharmacy software. I'm not sure the State has the adequacy or the resources to even broach that.

COMMISSIONER STECKEL: Well, and you reminded me of another component of this and I need to do my talking points so that I'm hitting every subject.

On the AWP, the reference pricing, AWP and WAC that we don't have any control over, the PBM's don't have any control over, what we're going to do is we know that the PBM's have a contract either with your PSAO's or--what we found out a couple of days ago is that apparently the PBM's

have a contract with your PSAO's and the independent pharmacies, the individual pharmacies, and in that contract, it says we will pay AWP minus eighty-seven or WAC minus ten, whatever it is.

If they change that contracted amount plus or minus 5%, they have to get our approval. So, even on the reference pricing things if they change that, but what we won't be looking at on the reference pricing is the movement of the AWP and the WAC for that exact reason.

MR. KAYE: So, are you going to be looking at the combined prices of certain drug categories, say, the anti-inflammatories versus the anti-infectives or are you going to be looking at 5% on individual products by NDC number? That's very different.

COMMISSIONER STECKEL: Now, on the MAC pricing, we will be looking at individual products. On the AWP and WAC pricing, the referencing pricing, we will be looking at that contract between the PBM and the pharmacy. And if it goes up plus or minus 5%, then, that would trigger SB 5. I'm glad you raised that because I had forgotten to point it out.

MR. KAYE: I've had experience

in this. Give me a call anytime and I can give you my opinion.

COMMISSIONER STECKEL: Absolutely. Thank you. We will take you up on that.

MS. STIGLITZ: So, one of the things, I think, of what we think is happening - and part of this is conjecture, part of this is there's evidence - is that because the guidance was aggregate, so, what happened was they took high-volume drugs that were being dispensed and dramatically dropped the reimbursement on those but increased reimbursement on drugs that were dispensed infrequently.

The other thing is that there is a - and I don't know what Concerta does - but Concerta is always the drug everybody points to as problematic, but there are drugs that don't have a MAC price established is my understanding.

And, so, therefore, it's WAC or something, but that gets calculated into the mix of the GER which complicates that calculation because it's based on AWP minus ABP and some things like that.

So, I think this has to do with the authorized generics, whatever Concerta is.

Concerta has been the drug that everybody points to since Senate Bill 117 and I don't know why.

COMMISSIONER STECKEL: What does Concerta do?

DR. FRANCIS: It treats ADHD.

DR. CARRICO: It's because there's two generics, an AB-rated and a non-AB-rated.

MS. MILLER: Right, and we have to comply and to choose the right one, but, then, the pricing is attached to the one we can't use.

MS. STIGLITZ: Which technically is a violation of Senate Bill 117 because Senate Bill 117 clearly says when you develop a MAC price for a drug, and arguably this would be WAC-- MAC in the statute is defined as how you reimburse for a generic drug.

What it says is when you develop that, you have to essentially MAC an A to an A or an A to an AB and, then, a B to a B, a C to a C and so on and so forth. That's part of Senate Bill 117 that's really never been enforced kind of, but we've always been in discussions with DOI about how to potentially enforce that, but that is clearly what the back of Senate Bill 117 says. And we had long discussions with PCMA about that language and how to

word it properly because there were concerns about over-the-counter drugs and how you account for them and the orange book and all those pieces.

DR. FRANCIS: And another thing on Concerta is many providers have preferences to one of those two generics for clinical purposes. So, that puts the pharmacies in a tight spot, too.

COMMISSIONER STECKEL: Well, the other good news in addition to the two new staffers we announced today, Jessin and Doug on board. So, we're fully staffed up in our Pharmacy and they both are doing an extraordinary job.

One of the things I think we're going to have to do in this area more than any other area is just kind of go through the existing statutes and make sure what we're doing is right and in compliance or if not.

DR. OYLER: I may reach out separately to get a little more information once I've had some time to kind of process and think through it. I think I understand what you're saying, that there's different products rated differently and what can and can't be tied to a specific price but at the same time----

COMMISSIONER STECKEL: So, it's

SB 117?

MS. STIGLITZ: Yes. It passed in 2016. It's KRS 304.17A and I can't remember the most important part of it, of course, but, yes.

COMMISSIONER STECKEL: This will help us. Unfortunately, we're dealing with - and I'm just going to be blunt - but a silo mentality where everything was in one person. That person is not here. And it's when you all bring things to our attention or when we happen to do some file research and find, oh, my gosh, here is an email.

So, bear with us, but keep bringing these things to our attention. Now that we're fully staffed and have the resources, we will be able to then go back through and make sure that we're doing things right.

MS. STIGLITZ: I think it's been wonderful working with you and hope we can keep it up. Again, like you always say, we don't always have to agree, but as long as we communicate, that's the important thing.

COMMISSIONER STECKEL: Well, the nice thing about the relationship that I have found over the past month is I thought I knew a lot about pharmacy and I'm still learning and that's the

same with Medicaid. I think I know a lot about Medicaid and I still learn, but it is so very helpful to have the on-the-ground, in-the-pharmacy experience to help us go through how do we make these decisions and know even the fact of the GER and that we've got to worry about that or this offset reconciliation could be just as harmful as beneficial. So, before we rush into something, let's look at the data, but I'm very, very grateful.

Keep in mind - and this goes to your negotiations with the MCOs - in Kentucky, one of the surprising data points that we found in our report is over half of the prescriptions are written by independent pharmacists.

DR. FRANCIS: Filled by.

COMMISSIONER STECKEL: Filled. I'm sorry. Filled. Yes, filled. Thank you. And I hope that you all have read the RFP that's on the street and that you feel that we were very responsive to some of your input and have addressed some of your issues in that.

DR. FRANCIS: I am. Before we move on from Senate Bill 5, I just wanted to, first of all, thank you. I reiterate what Shannon says. It has been very helpful to just understand some of

the details that are going through and be able to discuss front line what we're encountering with patients and bring it back.

I just wanted to ask the members of the TAC if you have any questions, comments, concerns to further bring to light for the Commissioner and her team?

MR. KAYE: My only question is does SB 5 affect the medically administered pharmacy also? So, in some cases, the same drug can be dispensed retail-wise versus administered by a professional.

MS. STIGLITZ: I think it just references outpatient pharmacy.

DR. OYLER: I believe so. It's just outpatient or drugs dispensed from a pharmacy.

DR. FRANCIS: Anything else?

COMMISSIONER STECKEL: Okay. So, that is consuming all of our time. I know Jessin and Doug have been reaching out to pharmacies as we've gotten emails. So, we're trying to be as open, but as you all have just heard how complicated and how careful we're trying to be, knowing we have a statute that we have to implement.

The update on the 1115

Waiver----

DR. FRANCIS: And that bullet point should go below the 1115 about the copays. Sorry. That was my fault on making the agenda, about the adjudication message for copays in case anyone is confused. That deals with the 1115.

COMMISSIONER STECKEL: Oh, I got it now. As you all know, the waiver is tied up in the court system. It is going through the appeals process now and will more than likely, depending on who wins, be appealed directly to the Supreme Court. We're not anticipating any changes, activities, implementation activities until July of 2020.

We actually are entering - someone told me this yesterday and it just felt so calming. Was it you, David, that said--why don't you tell us, then.

MR. GRAY: I just think we've got what I would say kind of stable or constant environment that's going to exist between now and really July 1 of 2020. And you may take issue with what that environment is but there isn't going to be a lot of--I mean, the things that are known we know right now with regard to what those issues are.

What we just spent the last

twenty minutes talking about are those things. So, we've got copays in place. The MCO contracts are out for bid which would go into effect July of 2020. The earliest Kentucky HEALTH would be implemented would be July of 2020.

So, it's a great opportunity to really do a lot of fine tuning of issues for providers and for the State.

COMMISSIONER STECKEL: Thank you. I guess with everything going on, it's like, wow. Now maybe we can look at some of the maintenance and operation issues that we need to improve, but that's the update on the 1115 Waiver.

DR. FRANCIS: The Kentucky Pharmacists Association sent out an interim legislative update that also included the copay regulations for $1 for generic and $4 for brand-name drugs.

And it was supposed to also include what we were speaking of last time, if the pharmacy needs to collect the copay or it's their decision that they don't have to, according to the Federal Poverty Limit.

I don't know if you can give feedback, if that's working, when it is implemented

which I think is----

COMMISSIONER STECKEL: January 1st.

DR. FRANCIS: It is January 1. I'm not in a pharmacy to see that.

MS. MILLER: Are you asking if we've seen the copay?

DR. FRANCIS: Yes and any knowledge of the patient notice.

COMMISSIONER STECKEL: I think one of the things that we had to do, too, is change our system to show the pharmacist----

DR. OYLER: I think that is correct.

COMMISSIONER STECKEL: The FPL level, that that wasn't and we have made that change.

DR. CARRICO: I know I've seen it on some. I know I've had a number of patients whose copays have changed two or three times this year already. Like one month it's zero. The next month it's $1 for each prescription and I'm trying to explain to them this is just what's coming back to me. I'm not behind it.

DR. COX: There's a quarterly maximum out-of-pocket; and if they hit that maximum

before the quarter ends, then, their copays go down to zero. And, then, when the new quarter starts, their copays kick back in.

DR. CARRICO: All right. That would be easier to explain because I think they think I'm creating copays or something.

COMMISSIONER STECKEL: It's 4% of their household income. So, once they hit that, then, exactly, the copay goes down to zero and, then, the new quarter it would go back up.

MS. MILLER: Do all the MCOs have that same rule?

MS. ROGERS: Yes. We get an indicator from the State telling us to charge a copay or to not charge a copay. And, then, the formulary status of the drug kicks in, whether it's a dollar or whether it's four.

DR. FRANCIS: I think that would be something great for KPhA to put an email blast out to pharmacists about just so they can describe that to patients and maybe give some rhyme or reason as to the copay.

COMMISSIONER STECKEL: Why don't you get someone to do just a very brief paragraph on this.

DR. OYLER: Sure.

COMMISSIONER STECKEL: And, then, we'll send it to--Suzanne, do you want us to send it to you or to KPhA directly?

DR. FRANCIS: Why don't you send it to myself and to Mark Glasper.

MR. GRAY: I don't know if you're accessing the MCO site or if you're going to KYHEALTH.Net. If you're going to KYHEALTH.Net, and, again, as Stephanie Bates always says, that ultimately is the source of truth with regard to the accuracy of information.

There's a tremendous amount of activity going on to do enhancements to those screens in KYHEALTH to try to get the copay information together. I think spelling out the fact that the acronym means Federal Poverty Level - not everybody knows what that means.

And, so, there are changes going into effect at the end of this month and additional changes going in by the end of June.

So, we really ask this body, as you get into July, when you're in KYHEALTH.Net, if you see things that don't look better, please let me know, and I'm at davidl.gray.

MS. MILLER: On the KYHEALTH.Net, are we able to get ID numbers for the individual MCOs because what happens at our level all the time is somebody comes in and they have no idea what insurance they're on.

So, I can get on there and I can say, oh, they're with Aetna, but, then, I wish I just had a way to click and get that number and then I would be good to go.

MR. GRAY: Well, let's talk after this meeting a little bit more about it.

DR. FRANCIS: And let's include that resource in that paragraph and hopefully we can help share that information with pharmacists.

MS. STIGLITZ: It was my understanding that pharmacists, as far as when the provider directions came out on the copays, there was you had to log into the KYHEALTH - this was when Dr. Liu was here.

Back in January, he and I were working to figure out if the copay process was working because there were complaints coming in from folks who were obviously exempt from the copay but the point-of-sale system at the pharmacy was telling them to collect it.

The access to KYHEALTH.Net for pharmacists wasn't the same as other providers. And, so, the goal was to make sure all that information about whether or not charging a copay was in the point-of-sale, and something what Thea is saying is it is. And, so, I just want to make sure that that is the process we're following.

In addition, there's state budget language that allows a pharmacist - and it's been there for a number of years - to dispense an emergency supply of a medication if a patient cannot pay the copay at that point in time but they would only get one dispensing fee when they follow up the full fill when the patient comes back, and that's been some confusion amongst pharmacists and Medicaid but I think we got that all cleared up. I hope so.

DR. COX: There was an information sheet that Jessin sent out that clarified what you're talking about. That way, everybody was sending out the same thing instead of all the MCOs sending out our own interpretation, I guess, for lack of a better word.

So, he provided us with direct language on how to apply the emergency supply, about the FPL and we sent it out, at least from Aetna, as a

fax blast which also included the messaging that would be at point-of-sale to let pharmacists know about the FPL.

DR. OYLER: So, I'll circle with Jessin, get everything from that information sheet, take information we've talked about now and set in into a paragraph that can be sent out.

DR. FRANCIS: Thank you.

COMMISSIONER STECKEL: Pharmacy-based immunization chart edits.

DR. OYLER: Jessin has been the point of contact for that actually for both of those two things. I don't personally have an update. That's mostly been Jessin. I don't know if you guys have been working with him or not.

DR. FRANCIS: So, Jessin did send me an email that he was still in process working through some of my questions. He said, yes, I was correct on one of the points.

And, so, I think we just need to finish up following up on that because that would be a nice thing to also submit to the pharmacists across the state.

MS. WILLIAMS: Suzi, did he send you the charts and ask you about looking at them

to see?

DR. FRANCIS: When? Recently?

MS. WILLIAMS: Yes.

DR. FRANCIS: No.

MS. WILLIAMS: Okay. Let me touch base with him.

DR. FRANCIS: Okay. No, I haven't seen the charts since you sent them several months ago and I sent back some questions.

MS. WILLIAMS: Because I think he wanted your feedback on some of the charts but I will touch base with him. He will be back tomorrow.

DR. FRANCIS: Okay. Perfect. We'll do that.

COMMISSIONER STECKEL: Okay. Communication collaboration between DMS and KPhA. I don't know what this is.

DR. FRANCIS: President Chris Palutis was here last month from KPhA and he had suggested maybe we could, what we were just doing, put together a paragraph and blast that out on some things that would help our pharmacists understand what's going on and the work that's being done instead of the grumbling about some things, just understand all the effort that is being put in but

just to help to provide that communication platform from the KPhA resources that they have.

So, maybe put together some type of communication plan for updates, even all of the work that you're doing on Senate Bill 5. That's helpful for our pharmacists to understand. I mean, that's a lot of detail but just a basic this is what's going on. This is why you're seeing differences in reimbursement and that kind of thing.

DR. OYLER: So, even perhaps building something in with--I mean, I imagine you guys have a newsletter or a List Serve or something that goes out on a regular basis.

So, even having a section of notes from DMS on those kinds of things that we send in, and this could fit in there some description, probably not immediately, but once we get a little more information around Senate Bill 5 and some of that, could fit into this kind of thing and the vaccine stuff with that as well. I think that would be reasonable.

DR. FRANCIS: Yes. Even right now, it's hold tight. I know there are lots of differences in reimbursements. We're working collecting some data for after June 1st to be able to

understand all of that.

COMMISSIONER STECKEL: So, Mark is the Executive Director?

DR. FRANCIS: Mark is the Executive Director. Sarah Franklin kind of handles a lot of the media.

COMMISSIONER STECKEL: So, why don't you all just get with Mark and Sarah and develop a plan of action. I think a newsletter type add-on is great and, then, they can help guide on what important subjects for each month or however often it goes out.

DR. OYLER: Sure.

COMMISSIONER STECKEL: Excellent. Okay. And, then, DMS Pharmacy Department Project Management?

DR. FRANCIS: You had just mentioned last time that you were getting a Project Manager on staff. So, I assume that is----

COMMISSIONER STECKEL: No. Actually, he's not here but he's on board. I can't say it with a straight face that we're fully staffed because you could always use more staff, but we're about as fully staffed as we'll ever get, and it includes a Project Manager, our existing team.

Anybody else new in Pharmacy? Doug and Jessin.

MS. WILLIAMS: We've added a BA, Business Analyst.

COMMISSIONER STECKEL: So, I feel very comfortable with the leadership of Jessin and Doug and the extraordinary staff, Leeta, that was already there and others and, then, the couple of new people we've gotten on board that we're in a good place.

DR. FRANCIS: That's wonderful. Thank you for clarifying that. Does the TAC have any other questions for DMS before we move on to the MCOs?

So, Joe, if he's still on the phone, or who will provide any updates, if you have any, from CareSource? We give you a chance to speak. You don't have to speak.

MR. STAPLES: I'll defer to Joe.

MR. VENNARI: Well, I really don't have any updates to make other than we're working through SB 5, and the release of the new RFP, we're beginning to work through that. That's really consuming most of our time right now.

DR. FRANCIS: Joe, I was going

to ask you the status of your RFP.

COMMISSIONER STECKEL: You're asking him about CareSource's?

MR. VENNARI: Humana-CareSource. We are looking to go live with that with RxInnovations which is our internal kind of PBM and we're using PSI as kind of the processor but essentially that will go into effect on 1/1.

DR. FRANCIS: Okay. Thank you.

MR. VENNARI: And that's actually one of the meetings I'm going to today. That's where I'm headed.

DR. FRANCIS: All right. Aetna. April.

DR. COX: I see we have CPESN pilot project update on the agenda. So, I just have a few numbers to share.

We still are just focused on the six pharmacies that we are contracted with as of 1/1. We are looking to expand. We're exploring some pharmacies across the state. No decision has been made yet on which pharmacies we will work with to add to the network but we are looking to expand before the end of the year.

But between the six pharmacies

that we have worked with in Bowling Green, we've opened or had ninety-four case referrals for members. We've already closed fifty-two of those. We've had twenty-four case conferences.

And, so, these conferences can be between the plan and the member based on a referral that CPESN sends to us after they've identified whatever issues they can handle on the pharmacy end. They will make a referral to our case managers for case management issues that the plan can address.

So, so far, it has proven to be pretty successful.

DR. FRANCIS: Because of all the new faces in the room, could you just explain the pilot project because I think it's great and I love that it's using pharmacists to help improve patient outcomes.

DR. COX: Sure. So, CPESN is Community Pharmacy Expanded Services Network. And, so, basically, it's an organization and they have independent pharmacies throughout the State of Kentucky that they partner with. So, CPESN is kind of, I guess, the middle person.

What we get to do, we get to

partner with them. We get to select specific pharmacies in the state. So, we chose to focus on one region initially for the pilot program which was in Western Kentucky, specifically in the Bowling Green area. So, we have pharmacies in Bowling Green, Beaver Dam, in the Western Kentucky area that we are initially working with. So, there are six of them.

And what we're doing, we are actually identifying - initially, it started off with just the plan identifying members that we thought would be good candidates for outreach. So, we started off very small.

We sent each pharmacy a list of five to six members just to initially get started and basically we identified the members through polypharmacy, so, through claims from point-of-sale and we sent those members to the pharmacies.

And what they do, they contact the members for outreach. They can catch them in the store when they're picking up scripts or they can contact them via phone. Some of them make house calls. So, they're on the front line. They know these people personally and they can get some information that sometimes from a case management perspective, it's a little bit harder to engage

because sometimes that face-to-face interaction, not sometimes, all the time, it's important.

And with the community pharmacists, they're building relationships with the patients every day. They may not be coming in just to get scripts. They're coming in to get some household items and come to the pharmacy counter and shoot the breeze. So, we recognize that as a way to increase our contact with our members to obviously improve their care.

So, they're identifying issues of social determinants of health that need to be addressed. We're doing care packages for the members, but initially it all starts from polypharmacy. So, the pharmacist will do an assessment of the member, review their medications.

DR. FRANCIS: Like a comprehensive med review.

DR. COX: Yes, basically.

DR. FRANCIS: And, then, are there any targeted interventions that the plan puts out like the social determinants?

DR. COX: So, just anything that they identify for social determinants, we need to be made aware of so that we can figure out an

avenue to get that member help to address that area or that issue.

From a medication perspective, they will do the full writeup of their medication history, compliance, gaps in care, if they are possibly being over-prescribed - they will identify any of those areas - if they're lacking immunizations, things that pharmacists do on a day-to-day basis but they're providing us a writeup of it with a care plan.

So, they identify the issues. They give us a care plan and go goals and, then, they are tracking those goals, if the member, were they able to contact the provider and get a medication switched or add a medication or contact the prescriber and say, hey, they're on for whatever reason an ACE and an (inaudible) - probably shouldn't be on both of those.

DR. FRANCIS: Does the primary care doc or the provider also get a copy of that care plan so they don't feel like they're siloed?

DR. COX: So, it's up to the pharmacist how they reach out, and we're dealing with some of the more rural areas in Kentucky. So, a lot of the pharmacists know the physicians personally.

So, they can send a fax. They can call and share the information with the provider of what they're seeing and make a recommendation for the provider but the care plan is funneled through CPESN and then they send them to the plan.

And, then, we have one dedicated case manager currently who reviews all of them, and if we expand, obviously we're going to have to add an additional two or three case managers to be able to handle the workload.

So, that's a quick synopsis.

DR. FRANCIS: What outcomes are you studying?

DR. COX: So, we're looking at whatever issues the pharmacies are identifying. So, we have medication-related ones. We're kind of putting these in buckets. And, again, this is a pilot, so, we're kind of doing this as we go.

We're just now starting to pull in data. As I said, the numbers I have were from May 15th and this is the first time because we were trying to wait until the first quarter ended, so, we're just now pulling in the data.

We're building in new buckets into our case management system to be able to track

all of this so that we will have some tangible data to share. It's just in the process.

We're looking at care gaps. We're going to be looking at their cost of care, ER utilization, things of that magnitude.

DR. FRANCIS: Okay. Great work. I know Paula is going to give us an update on CPESN at the Kentucky Pharmacists Association meeting in June because she has been very involved with it.

DR. COX: And I know you and I have been in contact with the smoking cessation. I haven't reached back out because I still don't have an answer.

MS. MILLER: I am still working through it. It's definitely a different model than we're used to working through. So, it's all a building process. So, I loved everything you said about how you're building on your side and the pharmacies need to build on their side, too, and as well as the physicians.

DR. FRANCIS: That's right, because Chris and I can then take it to the physicians that we work with and say this is what could be done at local pharmacies leveraging our community pharmacies to help improve care, catching

that patient where they're at.

So, great work, but this is what I have been talking about for the past year or so is how can we use our pharmacists to improve outcomes. We have to allow pharmacists to have time, so, we have to have staff which is why reimbursement is so important. We have to be able to pay for our pharmacists.

I commend Aetna for taking the chance and doing a pilot, and however we can help as a network of pharmacists, I would be glad to do that.

DR. COX: And we are looking specifically at a couple of different areas for gaps in care that we're doing internally for outreach or getting ready to, and we are considering bringing that to CPESN because it ties in with the care plans, but we want to look specifically like the diabetes and statin utilization and some cardiovascular areas, possibly osteoporosis.

So, there are some ideas that we have that we haven't implemented yet because we're still kind of just getting our feet wet, but I think in the next several months, this time next year, I think we're going to have tremendous growth in the program and I'm really, really excited about it.

DR. FRANCIS: Well, let us know when you're ready to come to Northern Kentucky.

DR. THERIOT: Looping the physician in with those care plans would be so important. A lot of times, they have care coordinators in their offices that might be doing similar things, so, you don't want to duplicate those services.

DR. FRANCIS: Well, and that's what I'm saying, too. I work in the ambulatory setting in the provider's office and so does Chris. And, so, when they can establish a method for how to outreach members, but, then, not fragment care.

And, also, I know Paula and I have been working on bi-directional communication and could you utilize labs to drive home----

MS. MILLER: And the platforms that are all part of this network are being built to communicate with the electronic health records. So, they're using HL-7. I've got the ability right now to send it out electronic but I've got to get the other side. So, it is all part of it.

DR. FRANCIS: Yes, how it coordinates into Epic or whatever is being used. So, to me, it's definitely the future as we push to

value-based care.

DR. COX: So, other than that, that's all I have.

DR. FRANCIS: All right. Thank you for that. Sorry to spend so much time on it but I think it's important. Thea, WellCare.

MS. ROGERS: So, not a lot really to update on, just also working to support the efforts with SB 5 and ensuring compliance and transparency there.

I know there was a directive to remove the prior auth of Vivitrol. So, we're working to get that implemented and there will be some communications to pharmacies advising you on how to submit ICD-10's for the diagnoses to bypass the authorization. So, hopefully that will help the opioid issue.

That's really the highlights. We're continuing to explore ways to partner with our pharmacies as well on definitely around Medicare. And, so, there will be some things that we will be rolling out and exploring in the near future, so, I will keep you abreast of those.

DR. FRANCIS: Anthem. Andrew.

MR. RUDD: Kind of the same.

Not a whole lot to report. We are also working on the Vivitrol, the ICD-10 code to allow that claim to pay. That lets us know that it's opioid addiction treatment other than alcohol addiction. So, that's kind of the biggest cog in that wheel that we're trying to make sure that it works appropriately and doesn't create more problems than it causes.

We are working internally looking at diabetic polypharmacy. We're seeing patients that are on three or more anti-diabetic medications and kind of looking at the appropriateness of that, along with the other non-anti-diabetic medications that they're taking as well, trying to make sure that those are all synergistic and appropriate care moving forward.

The opioid addiction crisis that we have, we are continuing to see an increase in SUD claims with Suboxone, Buprenorphine/Naloxone products. So, I think removing the PA on our preferreds is allowing more patients access to that drug. So, we are continuing to monitor that.

DR. FRANCIS: Has there been any work with - I know this is really outside the realm of pharmacy - but other means to expand coverage for total care for substance use disorder

like behavioral?

MR. RUDD: So, I don't know if the Commissioner maybe wants to talk about the SUD waiver, the 1115 SUD Waiver, but, yes, there is a more full health approach being implemented with that waiver.

And while pharmacy may not be as directly related with the Methadone component and the counseling component, we are involved in those conversations to make sure that we are looking at it from a holistic standpoint.

COMMISSIONER STECKEL: And thank you for raising that, and I should have at least touched on it. June 1st is the implementation date. In the Kentucky HEALTH waiver, there was an SUD 1115 Demonstration Waiver.

The courts held back everything except for that SUD waiver. So, that is moving forward for a June 1st implementation. And exactly as you said, it's more of a whole person, how do we create a system around a person view.

MR. RUDD: It's a multidisciplinary approach when you look at addiction treatment. And, so, the SUD waiver definitely takes that into consideration looking at that total scheme

of treatment, more than just SUD MAT component. It's everything.

DR. FRANCIS: Thank you. Passport.

MS. ARMSTRONG: So, we are also on track to have the Vivitrol PA in the system by 7/1. We will also be requiring the ICD-10 to be submitted with the claim as well. So, we'll have more guidance coming out as we get closer to that date.

We also have a lot of very focused work being done right now around our outreach pharmacists team. More recently, they have been very heavily focused on a lot of the providers in the community and we're trying to connect them more with the community pharmacies in the plan to try to connect all three, more focused on different quality measures.

So, right now, we're just looking at our data to try to figure out what we need to narrow in on, which providers we need to talk with and which pharmacies and try to work something out to where we're all kind of in the loop and working together on that.

DR. FRANCIS: Great. Thank you

for the updates.

PTAC members, any items that you have? I think maybe we should just go ahead and do you want to talk about your--it's under the New Business section?

MS. MILLER: Yes. Do you want me to do that now?

DR. FRANCIS: Yes, sure.

MS. MILLER: I had a pharmacist in a rural area of Kentucky reach out to me on this issue of a 90-day supply and also medsync. She was noticing, I guess, there are some plans that are not allowing a 90-day supply.

And in talking to Matt, I think most pharmacists would agree, 90-day isn't appropriate for every patient. For some patients, they may lose it and then you're really stuck for ninety days. This pharmacist had lots of rural patients who she felt if they had a 90-day supply, it would help improve compliance but she wasn't able to. So, I don't know where the plans are as far as allowing a 90-day supply.

Her other issue was medsync and you need to do partial-month bills where their meds are due on the same day. So, it's a process that's

in the pharmacy world. We're all really working towards this to help improve compliance and patient care, but she was concerned that their copays weren't being prorated when she was doing a partial fill.

DR. FRANCIS: Which Medicare does that, but in the Medicaid world, that would be helpful.

MS. MILLER: It would be helpful. She was doing some work trying to improve compliance on her patients and med utilization and she felt like these were some barriers.

So, if anybody has any input on that or whether your plans allow for either of those things, that would be helpful.

MS. ROGERS: I know we allow medsync. The pharmacist just enters in some authorization codes; but as far as the copay prorating, I will have to look into that.

MS. MILLER: Because if you're the patient and I'm trying to tell you, I'm going to give you ten days so I can give them all to you together, they don't want to pay $1 now and $1 later.

MS. ROGERS: Right, because I think when the medsync requirements first went in, we didn't have the copays.

MS. MILLER: So, if you could let us know on that.

DR. FRANCIS: And that's helpful work because that's been proven that they're getting ninety days and pickup can be prevent adherence. So, I appreciate that that pharmacist is trying to help with that.

MS. ROGERS: This may be a policy question to DMS. Are we permitted to prorate the copays in those circumstances? I know we were kind of told what to put on the copays.

DR. OYLER: I think that would be reasonable. And this is just my ignorance. You said ten days to get it all on the same thing. Would it be possible to do, given exceptions for controlled substances and so on and so forth, but I'm assuming most of these have refills and so you could possibly do forty days to get it altogether at the next time? Is that feasible? I don't know.

MS. MILLER: Well, and it would depend on whether the plan allows it. There's a lot of ifs, then's and whatnot and you can speak to some of this, too, because you and I were talking about it.

Number one, I wouldn't want to

see a forced 90-day. I don't know that that is a good answer, but if you're not going to allow a 60-day or a 90-day fill, you're not going to allow a 40-day fill.

DR. OYLER: Yes. That makes sense.

COMMISSIONER STECKEL: Let us look into the copay issue. It sounds reasonable, but sometimes federal law is not reasonable.

DR. FRANCIS: I had something unless Matt or Chris.

DR. BETZ: I had one thing. I didn't send it to you because, of course, it came through like yesterday, but a colleague of mine contacted me who works at Family Health Center in Louisville and they're running some test claims on - and I apologize because I have a minimal amount of information here - but they were running some test claims on vaccines in kids nine to eighteen and they're finding that the Quadrivalent flu vaccine wasn't being covered by Passport and CareSource when they tried to run it through, and they're trying to figure out--and, again, I wasn't there when the claims were adjudicated.

So, they just kind of brought

this up to me to see if anyone else was having any trouble because I know, according to our vaccine listing and so forth----

DR. FRANCIS: There are certain flu vaccines that I know that they cover and it's by NDC and it may just be a different Quadrivalent.

MS. ARMSTRONG: I'll check for Passport because I know we do have that on our vaccine list.

DR. BETZ: And when she contacted me, I said, well, it's on the list and I also asked was it the flu mist because there was one that wasn't--somebody wasn't covering it, and they said, no, it was actually the injection, but they just wanted me to ask about it to see if there was something that was missing.

MR. VENNARI: This is Joe. If you could get me that claim specifically, I'll definitely take a look into that.

DR. BETZ: That'S Joe. I will have my colleague forward that on to you. Thanks. Great.

MR. VENNARI: That would be great, and you're sure that they're part of the network because I've run into that before where

there's been changes in like the pharmacy VIP and they have to through the paperwork again.

DR. BETZ: I'll double check. Actually, I asked them to make sure that they're appropriately covered and everything else and they said yes, but, again, it was a colleague of mine that works at a clinic at the university and they were trying to make sure they could start doing this for their patients. So, I don't know all the details of it but I'll find out.

MR. VENNARI: Okay. Well, as much information you can send me, I will get on it.

DR. BETZ: Okay. Thank you.

DR. FRANCIS: And I guess that leads to my issue. So, I just wanted to make a note as we were talking about in real-world situations that affect patient care and I think this is really important to Medicaid members' health.

And I think Jessin so much because since October, I've tried to get our personal St. Elizabeth Outpatient Pharmacy to end the vaccine network with CVS Caremark PBM for the MCOs.

We've been doing vaccines but we can't vaccinate our Medicaid patients and we have high-risk populations. We run a Hep C clinic, HIV

clinic, oncology, and all of our St. Elizabeth physicians want to send all adult Medicaid patients over to be vaccinated in our med management clinic.

The issue we're having is CVS Caremark, we cannot contact a person. They keep saying--we have a different pharmacy manager than what they had on record, even though we've been in network with CVS Caremark for a long time but there's a different pharmacy manager.

And, so, we've tried to submit that paperwork. It's an online form that takes a long time to submit. They want Board of Directors, Social Security numbers. We're owned by the Diocese of Covington. There's no board.

We cannot talk to a person. So, what I've had to do, the only thing I could--they sent us an overnight letter saying that they're going to terminate our CVS Caremark PBM contract. And that obviously is very concerning.

We are actually up for an RFP with our St. Elizabeth employee PBM also and CVS Caremark is a contender. And, so, we've actually had to take it to them is the only way we can get it escalated through our legal team to look at it to talk to a patient.

I have Kenton County Schools that are waiting for 3,500 schoolchildren to be vaccinated for me to get this so they can go back to school next year. It's a huge issue. And Jessin and all of the directors have been tried, but I just happen to be the one working on this.

What is our pharmacy in Beaver Dam doing? You know, that's ridiculous. And I think as we consider the PBM issues, we have to consider this type of thing. Why can I not call somebody and work through this with them?

MS. STIGLITZ: By statute, they are to have - and this might be by regulations within DOI and I don't know if this will get you to a person - but they are required by regulation within DOI to have a contact person for issues.

So, it may be that you can try and most immediately to go through DOI, but this credentialing issue is becoming a national problem and a big problem for pharmacies. Credentialing fees are going up - CVS Caremark's fees, I think like maybe four times what they were in the past.

MS. MILLER: Well, it's $1,200.

DR. FRANCIS: I've submitted all of our credentials.

MS. STIGLITZ: And, by the way, if you mess up or if they have to call and ask you a question, they charge you like, what, two hundred and fifty bucks, seven hundred and fifty bucks or something like that.

COMMISSIONER STECKEL: Seriously?

MS. MILLER: And we have the exact same experience. You cannot speak to a person. I mean, it has taken us, we're on like month nine of trying to achieve just like electronic fund transfer. It just can't be done.

DR. FRANCIS: And they just say you need to submit the 455. Okay. So, I can't talk to them. I just get a random email back. And, so, I go on to the 455, Change of Ownership. We don't have a change of ownership Bishop but it's really just a different pharmacy manager.

I hate to say that every time Kroger or somebody has a different pharmacy manager, they make them do this, but, yes, it's very frustrating and it's delaying patient care. And I think as we look at the PBM issue, we need to know that.

MS. STIGLITZ: Because they get

credentialed through Medicaid and, then, they have to be credentialed through----

COMMISSIONER STECKEL: So, help me understand that because this is important and we are about to put out an RFP for our centralized credentialing verification organization.

So, you become enrolled in Medicaid. Currently, with each MCO, you choose to be credentialed with whichever MCOs you want. And, then, you also have to be credentialed with the PBM's and they charge you $1,200?

MS. STIGLITZ: Well, they will charge out----

MS. MILLER: If you're a new pharmacy----

MS. STIGLITZ: ----as of 7/1.

MS. MILLER: ----yes, you will pay $1,200 to become credentialed with them.

COMMISSIONER STECKEL: And, then, $250 to talk to them?

MS. MILLER: I haven't had that happen.

MS. STIGLITZ: There'S some kind of fee. I've sent Jessin the paperwork on this but I can resend it. There is some sort of--I just

brought that up because I thought that was interesting. If they have to call you and ask a question or one blank isn't filled out, yes, there is a fee for them to ask you a question.

DR. FRANCIS: I can't tell you how many hours I've spent on this and I'm not even the pharmacy manager - I run the med management clinic - but the pharmacy manager and I have just spent--now we're using our legal resources and our Assistant Director of Pharmacy, our Business Manager just to find a contact person.

COMMISSIONER STECKEL: And people still aren't getting vaccinated, kids.

DR. FRANCIS: I ran one this morning just to see and it still says not in vaccine provider network. And this is our patients with Hep C that we're treating, trying to give A and B, Hep A and B.

COMMISSIONER STECKEL: So, if you don't mind, Madam Chair, can I get on my soapbox for another second?

DR. FRANCIS: Yes, absolutely.

COMMISSIONER STECKEL: To the managed care companies in this room, if you want carved out of pharmacy, you continue to let the

PBM's do this. And I can guarantee you, you will not have pharmacy in your networks after this legislative session. This is reprehensible.

MR. GRAY: You sometimes wonder who is in control frankly----

COMMISSIONER STECKEL: Exactly.

MR. GRAY: ----whether it's the PBM or the MCO.

COMMISSIONER STECKEL: And I am all for people making money. I am all for there being systems, and I'm seeing less and less of it, but I'm being told there is a benefit of PBM's, but this is over-the-top ridiculous.

And I'm telling you all, as sure I'm sitting here, we will have a carve-out bill in the Legislature and I'm not going to fight it. So, you've got to get control of your contractors.

MR. KAYE: Suzi is licensed either as a hospital or a clinic and that is reported on the NABP number and on the pharmacy filings.

There's absolutely no reason why they cannot recognize a clinic pharmacy or a hospital pharmacy as a duly-registered provider for vaccines.

DR. FRANCIS: We have sent

multiples. We are a 501(c)3 organization by the Diocese of Covington and they said you need a Board of Directors----

MR. KAYE: That's a basic premise of healthcare.

DR. FRANCIS: Well, we actually didn't say that to them because we couldn't. I say it to my peers, though. It just so happens I'm able to contact you, but I can't imagine throughout our state the pharmacies that aren't able to vaccinate with those kinds of obstacles.

MR. KAYE: Because you're not buying vaccine on a 340(b), not for your clinic.

DR. FRANCIS: No. It's run through the pharmacy----

COMMISSIONER STECKEL: And that's our number one issue in Public Health today - vaccinations. And this is the kind of information we need, but I'm telling you guys, this is getting beyond ridiculous. Thank you.

DR. FRANCIS: I just appreciated the awareness.

MR. KAYE: PBM's have been pushing for a 90-day supply for years because historically it sells more product, also, on our end,

the State's end, increases more utilization, more wastage, more polypharmacy, returned goods, etcetera. So, ninety days works for many cases - chronic disease - but it certainly doesn't work for all disease and we end up having unintended consequences with a 90-day supply being open-ended, plus the PBM's, if they go ninety days, then, they're going to shove as much as they can through mail order which they make more money from based on the rebates and credits.

So, there's a tremendous amount of cross-pollination in all health care. Pharmacy touches everything and sometimes it turns out good and sometimes it turns out not so good.

DR. FRANCIS: I just wonder if we should make a recommendation to the MAC about these issues or if this is something we should just continue to work through, and I'm asking the Pharmacy TAC that.

COMMISSIONER STECKEL: Can I jump in?

DR. FRANCIS: Yes.

COMMISSIONER STECKEL: A recommendation to the MAC that advised the Medicaid agency, so, if the Medicaid agency has the power or

authority to do something, I would recommend yes; but if we have no authority or power to do something, what would be the recommendation?

DR. FRANCIS: Well, I guess it was just an awareness that this is going on. If we continue to have PBM working outside----

COMMISSIONER STECKEL: That's a very, very good point.

DR. FRANCIS: ----what's reasonable, then, Medicaid should be aware of that. I don't know exactly how to formulate that, and it may be something that we can talk about. I realize the MAC is Thursday.

COMMISSIONER STECKEL : And it could be that - and I'm sorry to jump in - but it could be that you say something along the line of, during the TAC meeting, Medicaid was made aware of this practice.

And, then, that way, you're informing the MAC because I thin it is important that they know, but, then, they understand that we had that communication and the action item is actually being taken already. Does that make sense?

DR. FRANCIS: Yes. We can talk through that.

DR. BETZ: We'll figure that out.

DR. FRANCIS: Are there any other recommendations from the TAC for the MAC?

Any other business we haven't covered today? Very informative for us and I think there's lots of good work going on, a lot of things to communicate to our pharmacists across the state to hopefully help minimize frustration back to you.

So, thank you for everyone that's here today.

COMMISSIONER STECKEL: Thank you all for your time.

DR. FRANCIS: So, I guess I will adjourn. Chris will be there on Thursday. Our next meeting is July 23rd and the MAC meeting will be just two days later. So, as things come up, go ahead and just send them to me and I will compile them for our next meeting.

MEETING ADJOURNED